SKILL	INDICATION	STANDING ORDER	CONTRAINDICATION	COMMENTS
Blood sampling Venous/capillary	Obtain blood sample to determine treatment.	Yes	None	Repeat BS not indicated en route if patient is improving
Broselow Tape	Determination of length for calculation of pediatric drug dosages and equipment sizes.	Yes	None	Base dosage calculation on length of child. Refer to pediatric chart for dosages (P-117). Children ≥ 37 kg. follow adult protocols and medication dosages regardless of age.
Cardioversion: synchronized	Unstable VT Unstable, unconscious SVT Unstable, unconscious Atrial fibrillation/flutter and HR ≥180	Yes	**Pediatric:** If defibrillator unable to deliver <5 J or biphasic equivalent	In addition to NTG patches, remove chest transderrmal medication patches prior to cardioversion.
	Unstable, conscious SVT Unstable, conscious Atrial Fibrillation/Flutter HR ≥180(*BHPO*)	No		
CPAP	Respiratory Distress	Yes	CPR, Vomiting, Age<15, possible pneumothorax, facial trauma, unable to maintain airway	
Defibrillation	VT (pulseless) VF	Yes	None	In addition to NTG patches, remove chest transderrmal medication patches prior to defibrillation.
Dermal Medication	When route indicated.	Yes*	Profound shock, CPR, Peds	Avoid application to areas that may be used for cardioversion.

Approved:

EMS Medical Director

SKILL	INDICATION	STANDING ORDERS	CONTRAINDICATIONS	COMMENTS
ET/ETAD Medication	When ET/ETAD route is indicated	Yes*	None	**ET**: Dilute adult dose to 10ml & peds dose to 3ml with NS. **ETAD:** Esophageal placement, via Port #1 (blue). Epinephrine 10mg diluted to 20ml volume. Tracheal placement – Medications same as ET dose via Port #2 (white).
EKG monitoring	Any situation where potential for cardiac dysrhythmia.	Yes	None	Apply monitor before moving patient with chest pain, syncope, or in arrest. Document findings on PPR and leave strip with patient.
12 lead EKG	Chest pain and/or Signs and symptoms suggestive of myocardial infarction.	Yes	None	Consider atypical presentations especially in elderly, diabetics and women. Report STEMI: ***Acute MI" or ***Acute MI Suspected" Also report Left Bundle Branch Block (LBBB), paced rhythm or SVT for exclusion from STEMI assessment Document findings on the PPR and leave EKG with patient.
End tidal CO_2 Detection Device	All intubated patients	Yes	None	Monitor continuously after ET / ETAD insertion May not detect CO2 levels in pulseless rhythms. Use Pedicap in patients <15 kgs.
End tidal CO_2 Detection Device – Capnography (optional)	All intubated patients Respiratory distress Trauma	No	None	Monitor continuously after ET / ETAD insertion May not detect CO2 levels in pulseless rhythms.
Esophageal Detection Device-aspiration based	All intubated patients	Yes	Patient <20 kg	Repeat as needed to reconfirm placement. Use for both ET/ETAD.

Approved:

EMS Medical Director

SKILL	INDICATION	STANDING ORDER	CONTRAINDICATIONS	COMMENTS
External Cardiac Pacemaker	Unstable bradycardia with a pulse refractory to Atropine 1 mg	No	None	BHPO Document rate setting, milliamps and capture
Glucose Monitoring	Symptomatic ?hypoglycemia	Yes	None	Repeat BS not indicated en route if patient is improving
Injection: IM	When IM route indicated	Yes*	None	Usual site: Deltoid in patients >3 yo. Vastus lateralis patients <3 yo.
Injection: SC	When SC route indicated.	Yes*	None	Preferred site-fatty tissue of upper arm.
Injection: IVP	When IVP route indicated	Yes*	None	
Injection: Direct IVP	When direct IVP route indicated	Yes*	None	
Intubation- ET/Stomal	Apnea or ineffective respirations for unconscious patient or decreasing LOC. Newborn deliveries if HR<60 after 30 seconds of ventilation To replace ETAD if: • ventilations inadequate OR • need ET suction OR • need to give ET medications	Yes	? Opioid OD prior to Narcan.	3 attempts per patient SO Additional attempts BHPO Attempt=attempt to pass ET (not including visualizations and suctioning). Document and report SD BREATHE. Reconfirm and report EtCO2 and lung sounds after each pt movement. Extubation per BHO. ET Depth Pediatrics: Age in years plus 10. When using uncuffed tube, immobilize spine.
ETAD (Combitube)	Apnea or ineffective respirations for unconscious patient or decreasing LOC.	Yes	Gag reflex present Patient <4' tall. ? Opioid OD prior to Narcan. Ingestion of caustic substances. Hx esophageal disease. Laryngectomy/Stoma	Extubate per BHO. Use Small Adult size tube for pts 4'-5'6" tall and Use Adult size for patients > 5' tall. Report and document SD BREATHE and ventilation port number. Reconfirm and report EtCO2 and lung sounds after each pt movement.

Approved:

EMS Medical Director

SKILL	INDICATION	STANDING ORDER	CONTRAINDICATION	COMMENTS
Magill Forceps	Airway obstruction from foreign body with decreasing LOC/unconscious	Yes	None	
Nasogastric / Orogastric tube	Gastric distention interfering w/ ventilations	Yes	Severe facial trauma. Known esophageal disease.	
Nebulizer, oxygen powered	Respiratory distress with: • Bronchospasm • Croup-like cough • Stridor	Yes*	None	Flow rate 4- 6 L/min. via mouthpiece; 6-10 L/min. via mask/ET.
Needle Thoracostomy	Severe respiratory distress with unilateral, absent breath sounds and systolic BP <90 in intubated or positive pressure ventilated patients.	No	None	BHO Use 14g IV catheter Insert catheter into anterior axillary line 4th/5th ICS on involved side (preferred) **OR** Insert into 2nd/3rd ICS in Mid- Clavicular Line on the involved side. Tape catheter securely to chest wall and leave open to air.
Nasogastric intubation	Uncuffed intubations. Gastric distention interfering w/ ventilations	Yes	Severe facial trauma. Known esophageal disease.	
Prehospital Pain Scale	All patients with a traumatic or pain-associated chief complaint	Yes	None	Assess for presence of pain and intensity
Prehospital Stroke Scale	All adult patients with suspected Stroke/CVA	Yes	None	Assess facial droop, arm drift, & speech.

Approved:

EMS Medical Director

SKILLS	INDICATION	STANDING ORDER	CONTRAINDICATION	COMMENTS
Pulse Oximetry	Assess oxygenation	Yes	None	Obtain room air saturation if possible, prior to O_2 administration.
Re-Alignment of Fracture	Grossly angulated long bone fracture	Yes	None	Use unidirectional traction. Check for distal pulses prior to realignment and every 15 min. thereafter.
Removal of Impaled Object	Compromised ventilation of patient with impaled object in face/cheek or neck.	Yes	None	
Spinal Stabilization	Spinal pain of ?trauma MOI suggests ?potential spinal injury Uncuffed Intubations	Yes	None	Pregnant patients (>6mo) tilt 30 degree left lateral decubitus. Optional if **all of the following are present and documented:** Adult Patient 1. awake, oriented to person, place & time 2. no drug/ETOH influence 3. no pain/tenderness of neck or back upon palpation 4. no competing pain 5. cooperative Pediatric Patient N=no altered LOC E=evidence of obvious injury absent C=complete spontaneous ROM without pain K=kinematic (mechanism) negative
Valsalva Maneuver	SVT	Yes	None	Most effective with adequate BP D/C after 5-10 sec if no conversion
VASCULAR ACCESS External jugular	When unable to establish other peripheral IV and IV is **needed for definitive therapy ONLY.**	Yes	None	Tamponade vein at end of catheter until tubing is securely attached to cannula end.

Approved:

EMS Medical Director

SKILL	INDICATION	STANDING ORDER	CONTRAINDICATIONS	COMMENTS
Extremity	Whenever IV line is needed or anticipated for definitive therapy.	Yes	None	Use extension tubing for suspected STEMI and *** Acute MI***
Indwelling Devices	Primary access site for patients with indwelling catheters **if needed for definitive therapy ONLY**	Yes	Devices without external port	Infuse at a rate to support continuous flow and prevent backflow into IV line. Needleless systems may require adaptor. Examples include Groshong, Hickman, PICC lines.
Intraosseous	Fluid/medication administration in acute status pediatric patient < 8 years old when unable to establish other IV.	Yes	Age ≥ 8 years Tibial fracture Vascular Disruption Prior attempt to place in target bone	Splint extremity. Observe carefully for signs of extravasation. Do not infuse into fracture site. Neonate < 28 days old BHO (<1 cm in depth). Do not use spring-loaded IO needles.
Percutaneous Dialysis Catheter Access(e.g. Vascath)	Unable to establish other peripheral IV and **IV is needed for definitive therapy ONLY.**	Yes	None	Vas Cath contains concentrated dose of Heparin which must be aspirated PRIOR to infusion. Infuse at a rate to support continuous flow and prevent backflow into IV line. Needleless systems may require adaptor.
Shunt/graft - AV (Dialysis)	Unable to establish other peripheral IV and **IV is needed for definitive therapy ONLY.**	Yes	None	Prior to access, check site for bruits and thrills. Access fistula on venous side (weaker thrill). Inflate BP cuff around IV bag to just above patient's systolic BP to maintain flow of IV. If unsuccessful, hold direct pressure over site for 10" to stop bleeding. Do not apply pressure dressing.

* When medication by that route is a SO.

Approved:

EMS Medical Director